Dear Colleague,

Welcome to our Health and Wellbeing in Education assessment pack. As we move closer towards the launch of the Education, Health and Care (EHC) Plan later this year, education professionals will need an even greater awareness of the elements that can affect a child and young person’s development.

This pack focuses on assessment and intervention tools that are suitable for addressing social, emotional and behavioural needs.

There is a growing awareness of the immediate and long-term effects of bullying, self-harm and suicide issues amongst school age populations; and we have seen an increased diagnosis of cases of Attention Deficit Disorder and Autism Spectrum Disorders (including Autism and Asperger’s). With these developments there is a clear call for assessments and intervention products that meet the needs of children, young people and adults.

Pearson Assessment is one of the UK’s leading publishers of standardised assessments. Our tests are used by a number of professionals in both educational and clinical settings e.g. Teachers, SENCOs, Psychologists, Speech and Language Therapists, and Occupational Therapists. We are dedicated to publishing a range of assessments that can aid in the identification of many of these areas enabling you to provide the support and intervention needed.

In this pack you will find:
• An overview of assessments covering social, emotional and behavioural difficulties.
• Individual assessment product bulletins - including case studies and related products.
• Your Area Sales Consultant details
• Details on where to find further information and stay in touch with our developments.

If you have any queries regarding orders or pricing please contact Customer Services on 0845 630 88 88 or visit our website www.pearsonclinical.co.uk.

To keep up to date visit www.pearsonclinical.co.uk/enewsletters where you can register to receive our bimonthly enewsletter. Plus you can now follow @PsychCorpUK on Twitter and share us your views on Facebook www.facebook.co.uk/psychcorpuk.

Yours faithfully,
Simone Lewendon

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The Self Image Profiles (SIP) is a brief self report measure of both self-image and self-esteem. There are two forms: the SIP for children aged 7–11 years and the SIP for adolescents aged 12–16 years. Both have identical format and scoring procedures but have different item content appropriate for the respective age levels.

Both the SIP–C and SIP–A consist of 25 familiar self descriptions, 12 of a positive nature (e.g., Happy, Friendly), 12 with a negative slant (e.g., Lazy, Moody) and one item on sense of difference. All statements were generated by children or adolescents. The participant indicates ‘How they think they are’ and ‘How they would like to be’ using a 0–6 scale (not at all to very much).

**Features**

- Can be administered with groups as well as individually.
- Immediate visual profile is obtained.
- Quick and easy to administer (10 - 20 minutes).
- Valuable in planning where to direct intervention programmes.
- Cut scores for negative and positive self-image and self-esteem.
- Sense of difference score also available.
- Aspects of self-information can be obtained in the following domains:

  **SIP–C:**
  Behaviour; Social; Emotional; Outgoing; Academic; Resourceful; Appearance.

  **SIP–A:**
  Expressive; Caring; Outgoing; Academic; Emotional; Hesitant; Feel Different; Inactive; Unease; Resourceful.

  * Recommended follow up questions available.
  * Alternate ratings available e.g., ‘how peers see me’ and ‘how parents see me’.
  * UK standardisation.

**Use in clinical practice**

As a Psychologist doing assessments for the court in both public and private law cases I often use the Butler Self Image Profiles for Children (SIP–C) and Adolescents (SIP–A). I find these useful tools to inform my assessment about how children currently see themselves and their perceived levels of self-esteem and also how they would like to be. I am then able to compare their self-image with how significant others (teachers, carers, parents) see them and this opens up areas for discussion and informs intervention.

Patricia Buxton, Chartered Psychologist, Child Psychology Associates
Overview

The Self Image Profile for Adults (SIP–Adult) is a brief self report measure for those aged 17 years to 65 years, that taps the individual’s theory of self. It provides an extension to the child (SIP–C: 7-11 years) and adolescent (SIP–A: 12-16 years) profiles, having a similar structure and format.

The SIP–Adult consists of 32 items rated by the respondent in terms of both how they think of themselves and how they would like to be. It provides a visual display of self-image, enabling the individual – as they complete it– to reveal to themselves as well as the clinician, ways they construe themselves.

In addition the SIP–Adult also provides a measure of self-esteem, which is estimated by the discrepancy between ratings of ‘How I am’ and ‘How I would like to be’.

The SIP can be used in research to gather an estimate of self-image and self-esteem; in clinical practice to identify aspects where the person wishes to change; or employed wherever an estimate of an individual’s self construing is considered appropriate.

It can be employed by Psychologists, Mental Health Workers, Counsellors and Specialists working with adults in a variety of situations.

Features

- Identifies both self-image and self-esteem.
- Items are short well-known descriptions, based on frequently elicited accounts, self derived from a large sample of adults.
- British norms based on samples drawn from across the UK.
- Identifies where people wish to change and therefore offers therapeutic avenues.

Why Choose SIP?

- Easy and quick to administer and score.
- Administration can be completed individually or in groups in around 7–15 minutes.
- May be used as a screening instrument where a quick assessment of self is required.

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Overview

The Resiliency Scales for Children and Adolescents™ were designed to systematically identify and quantify core personal qualities of resiliency in youth, as expressed in their own words about their own experience(s). The resiliency scales are designed with recognition that external events are important and that the child’s perception of external events is highly significant.

The Resiliency Scales are three brief self-report scales designed to identify areas of perceived strength and/or vulnerability in youth aged 9 -18 years. Each scale focuses on one area of resiliency: Sense of Mastery, Sense of Relatedness, and Emotional Reactivity.

Features

The self-report items are easy to understand as they are written at a reading age of 8 years. The scales can be administered to an individual or a group.

For each scale the respondent indicates how often they experience the feelings or experiences being described; 0 being never, 1 rarely, 2 sometimes, 3 often and 4 almost always:

Sense of Mastery Scale
The Sense of Mastery Scale is a 20-item self-report questionnaire consisting of three conceptually related content areas:

• Optimism - about life and one’s own competence. Positive attitudes about the world/life in general and about one’s own life currently and in the future.
• Self-Efficacy - one’s approach to obstacles or problems and one’s ability to develop problem solving strategies.
• Adaptability - flexibility, being personally receptive to criticism and learning from one’s mistakes.

Sense of Relatedness Scale
The Sense of Relatedness Scale is a 24-item self-report questionnaire consisting of four conceptually related areas:

• Trust - when others are perceived as reliable and accepting, and the degree to which an individual can be authentic in these relationships.
• Support - an individual’s belief that there are others whom he or she can turn to when dealing with adversity.
• Comfort - comfort with others which may buffer stressors in an individual’s life.
• Tolerance - the individual’s belief that he or she can safely express difference within a relationship.

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Emotional Reactivity Scale
The Emotional Reactivity Scale is a 20-item self-report questionnaire consisting of three conceptually related areas:

- Sensitivity - threshold for reaction and the intensity of the reaction.
- Recovery - the ability to bounce back from emotional arousal or disturbance of emotional equilibrium.
- Impairment - the degree to which the adolescent is able to maintain an emotional equilibrium when aroused.

Technical Information
For all ages, the Resiliency Scales have moderate to high alpha coefficients. For example, .94 for emotional reactivity, .95 for mastery and relatedness. Test-retest coefficients were moderate to high, indicating some stability over time.

The test correlated with Reynolds Bully Victimization Scales for Schools, Brown Attention Deficit Disorder Scales and Beck Youth Inventories™ - Second Edition For Children and Adolescents (BYI-II™).

Why choose Resiliency Scales for Children and Adolescents™?

- Brief and easy to administer.
- Short psychometrically sound scales.
- Produces theoretically and empirically sound results that are easily communicated to the adolescent and his or her caregivers.
- The scales can be administered individually or in any combination depending on the clinical needs of the youth.
- The items pertain to everyday functioning and not stigmatising.
- Profile analysis allows examiner to determine where personal strengths and weaknesses lie.
- Items reflect positive-self.

Links to other measures

- Reynolds Bully Victimization Scales - Generate interventions based on strength enhancement to counter bullying and victimisation.
- Brown ADD Scales - Generate interventions to address emotional reactivity and low sense of mastery that may accompany ADHD.

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Beck Youth Inventories™ – Second Edition (BYI-II)

Overview

Beck Youth Inventories™ – Second Edition are five self-report scales that may be used separately or in combination to assess a child’s experience of depression, anxiety, anger, disruptive behaviour and self-concept. The inventories are intended for use with children and adolescents between the ages of 7 and 18 years.

The BYI-II provides easy to administer and brief (5–10 minutes each) assessments of distress in children and adolescents. Each inventory contains 20 statements about thoughts, feelings or behaviours associated with emotional and social impairment in children and adolescent.

Features

The self-report items are easy to understand as they are written at a reading age of 7 years. The respondent indicates how often they experience the feelings described; 0 being never, 1 sometimes, 2 often and 3 always:

• Beck Depression Inventory – includes items that reflect the respondent’s negative thoughts about himself or herself, his or her life, and future; feelings of sadness; and physiological indications of depression e.g. “I feel no one loves me” and “I feel empty inside”.
• Beck Anxiety Inventory – includes items reflecting fears (e.g. about school, getting hurt, their health) worrying and physiological symptoms associated with anxiety e.g. “I am afraid that I will make mistakes”, “My hands shake”.
• Beck Anger Inventory – includes items or perceptions of mistreatment, negative thoughts about others, feelings of anger, and physiological arousal e.g. “when I get mad, I stay mad”, “I think my life is unfair”.
• Beck Disruptive Behaviour Inventory – includes items related to behaviours and attitudes associated with conduct disorder and oppositional-defiant behaviour e.g. “I like to hurt animals”, “I like it when people are scared of me”.
• Beck Self-Concept Inventory – includes items that explore self-perceptions such as competence, potency, and positive self-worth e.g. “I feel proud of the things I do”, “I’m happy to be me”.

Case Study: Joseph, 12 Year–Old Male

Joseph was a 12-year-old male who was referred for a psychological evaluation by a counsellor at an emergency children’s shelter in a small Southern city in the US. His mother, who complained that she could no longer cope with his defiance, anger and general behaviour problems, and had placed Joseph at the shelter. She reported that he was born healthy and his developmental milestones were within normal limits. Although he did not demonstrate any discipline problems prior to the second grade, problematic behaviours gradually increased from the third to the sixth grade, especially after his parents divorced and his father moved to another state.
At the time of the assessment, his mother felt overwhelmed by his problems and reported that she needed a respite from Joseph. She reported that he demonstrated frequent rages and she stated, “He doesn’t care how he treats others. He has no respect for others or their belongings. Everything is always negative and nothing is ever Joseph’s fault.” Behaviour ratings from her perspective and that of Joseph’s four teachers confirmed the pervasive nature of his oppositionality and anger across multiple environments. He was described by his teachers as being “oversensitive,” “touchy” and “obstructive.”

Despite these reports, Joseph was pleasant and cooperative during testing. He willingly completed all five of the inventories; his approach to the measures appeared thoughtful and honest. His responses were comparable to the reports of others, especially in the areas related to acting out behaviour. He obtained the following total raw scores: BSCI-Y = 37, BAI-Y = 22, BDI-Y = 32, BANI-Y = 40, and BDBI-Y = 29. The table below show how these raw scores convert to T scores. Joseph reported significant acting out (98% of the standardisation group scored below this level), had severe levels of anger and depression and had low self-concept.

An analysis of the items Joseph endorsed demonstrated that he reported that he “often” (or “always”) demonstrated oppositional and defiant behaviours, such as arguing with adults and being spiteful and vindictive, but he denied most Conduct Disorder symptoms (consistent with the reports of others). He reported victimisation cognitions at an increased level, such as believing people were unfair to him, and that others try to control him and put him down. In addition, he reported frequent anger effect, such as feeling like exploding.

Importantly, depressive symptoms and low self-concept had not been reported by others. He reported negative views of himself and his world, including hating himself and believing that his life is bad. He did not report vegetative symptoms or suicidal ideation, though hopelessness was sometimes experienced. Negative self-concept items were particularly predominant in his self-view and in his relationships with others. Overall, Joseph presented as a young man who appeared to honestly report oppositional and defiant behaviours; he felt victimised by others and felt intense anger. He experienced a sense of rejection by others and reported self-hate.

The use of the inventories identified the presence of internalising symptoms that may have otherwise been overlooked. The BYI-II inventories expanded the range of possible therapeutic options to include the following: (a) medication to address self-depression and depression-based irritability, (b) individual therapy to address self-hatred, and (c) group therapy to address his negative self-concept of interpersonal relatedness.
For the first phase (1999–2000) the normative data was based on a sample of 800 children ages 7–14 years. The second phase of data collection focussed on obtaining normative data for adolescents between the ages of 15 and 18 years (N=200). Reliability and validity evidence for all ages is excellent, for example internal consistency ranges from .86 to .96 for all five inventories.

Clinical samples were collected from a US population at each phase and included adolescents who have been diagnosed with depression, anxiety disorder, conduct disorder and bipolar disorder.

**Why Choose BYI-II?**

- Brief and easy to administer. They have fewer items than most other measures on the market, but do not sacrifice reliability and validity.
- Addresses the comorbidity of disorders of negative effect. Collectively they are broad in scope, individually each is a relatively specific measure of functioning.
- Short, psychometrically sound scales.
- Profile analysis available to assist in conceptualising how depression, anxiety and anger may all be part of a child’s distress.

**Links to Other Measures**

- Resiliency Scales for Children and Adolescents™

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Overview

By using the above scales together it is possible to obtain a comprehensive picture of a child or adolescent’s distress, behaviour, vulnerability, reactivity and resiliency to adversity.

The information provided by the Resiliency Scales for Children and Adolescents™ may be applied in treatment planning and used with additional information gained from the Beck Youth Inventory™ – Second Edition, enabling you to implement effective interventions that work with an individual’s strengths and coping styles.

On the following three pages there is a case study using test results from the Resiliency Scales for Children and Adolescents™ and Beck Youth Inventories™ – Second Edition, as presented in the Resiliency Scales Manual, published by Pearson Assessment.

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As previously stated, Michael had been in residential treatment at the time of testing and had experienced many previous hospitalizations and failed treatments. Michael’s background suggested that he had experienced multiple adverse circumstances. Neither parent had graduated from high school. His mother had an 8th grade education, and his father had an 11th grade education. His father, who did not live with the family, was reported as being employed as a laborer. On a negative life events checklist (developed by the author for use in this study) completed at the time of testing, Michael reported ten out of a possible thirteen negative life events and three out of a possible five negative life outcomes. Only 2.1% of the standardization sample had reported more negative life events. Three percent of the standardization sample had reported more negative life outcomes, and two percent of the standardization sample reported a higher total score of negative life events and outcomes. Given this report, Michael may be considered to have experienced cumulative risk factors.

<table>
<thead>
<tr>
<th>Table 3.4</th>
<th>BYI-II Score Summary for Michael</th>
</tr>
</thead>
<tbody>
<tr>
<td>BYI-II</td>
<td>Name</td>
</tr>
<tr>
<td>BDI-Y</td>
<td>Depression</td>
</tr>
<tr>
<td>BAI-Y</td>
<td>Anxiety</td>
</tr>
<tr>
<td>BAN-Y</td>
<td>Anger</td>
</tr>
<tr>
<td>BDBI-Y</td>
<td>Disruptive Behavior</td>
</tr>
<tr>
<td>BSCL-Y</td>
<td>Self-Concept</td>
</tr>
</tbody>
</table>

Michael’s BYI-II profile indicates moderate to extreme elevation in all of the negative affect and behavior inventory scores, indicating psychological symptoms (see Table 3.4). His highest scores were in anxiety ($T = 77$) and anger ($T = 70$), which were in the extremely elevated range. His depression and disruptive behavior scores were in the moderately elevated range. Michael’s self-concept T score was in the average range.

On the Resiliency Scales, Michael reported an average amount of Emotional Reactivity with two subscale scores in the upper average range. He reported a low Sense of Mastery score, particularly with respect to a sense of Optimism and Self-Efficacy. Michael’s Resiliency Profile is similar to the profiles characteristic of youth who have clinical diagnoses, although his Emotional Reactivity score is in the average range, Michael’s average Emotional Reactivity may be related to his maintenance on medication. Michael’s Resource Index score of 40 is in the low range and was obtained by only 14% or fewer of the males in his age group. His Vulnerability Index score of 57 is in the above average range and was obtained by 18% or fewer of the males in his age group.

See Table 3.5 and Figure 3.10 on the following page

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On the Resiliency Scales, Michael reported an average amount of Emotional Reactivity with two subscales in the upper average range. He reported a low Sense of Mastery, particularly with respect to a sense of Optimism and Self-Efficacy. Michael’s ADHD has probably compromised his ability to experience success, which may have been compounded by difficult life circumstances. His ability to acknowledge mistakes and accept help from others as indicated on the Adaptability subscale is average. His Sense of Relatedness is also low with respect to the Trust, Support, Comfort and Tolerance subscale scores.

**Fig 2.0 Resiliency Scale and Subscale Score Summary for Michael**

<table>
<thead>
<tr>
<th>Scales/Subscales</th>
<th>Raw Score</th>
<th>T Score</th>
<th>Scaled Score</th>
<th>Cumulative Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of Mastery</td>
<td>45</td>
<td>40</td>
<td>14.5</td>
<td></td>
</tr>
<tr>
<td>Optimism</td>
<td>13</td>
<td>6</td>
<td>12.5</td>
<td></td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>23</td>
<td>7</td>
<td>21.0</td>
<td></td>
</tr>
<tr>
<td>Adaptability</td>
<td>9</td>
<td>10</td>
<td>47.5</td>
<td></td>
</tr>
<tr>
<td>Sense of Relatedness</td>
<td>54</td>
<td>38</td>
<td>13.0</td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>16</td>
<td>7</td>
<td>17.5</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>15</td>
<td>7</td>
<td>18.5</td>
<td></td>
</tr>
<tr>
<td>Comfort</td>
<td>8</td>
<td>6</td>
<td>11.5</td>
<td></td>
</tr>
<tr>
<td>Tolerance</td>
<td>15</td>
<td>7</td>
<td>21.0</td>
<td></td>
</tr>
<tr>
<td>Emotional Reactivity</td>
<td>28</td>
<td>54</td>
<td>62.5</td>
<td></td>
</tr>
<tr>
<td>Sensitivity</td>
<td>6</td>
<td>9</td>
<td>44.5</td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td>6</td>
<td>12</td>
<td>77.5</td>
<td></td>
</tr>
<tr>
<td>Impairment</td>
<td>16</td>
<td>12</td>
<td>84.0</td>
<td></td>
</tr>
<tr>
<td>Resource Index</td>
<td>39</td>
<td>40</td>
<td>14.0</td>
<td></td>
</tr>
<tr>
<td>Vulnerability Index</td>
<td>14</td>
<td>57</td>
<td>82.0</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 3.10 Resiliency Scale Profile for Michael**

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Treatment Recommendations for Michael

Michael appears to be facing adulthood with very low optimism about his own abilities and less than average comfort with others. His ADHD and negative life circumstances may have compromised his ability to experience an adequate sense of mastery and sense of relatedness. His elevated BYI-II scores, in spite of ongoing treatment and medication, may be related to his overall worry about his future as he approaches his 18th birthday. Michael’s profile, which is high in symptoms and low in perceived strengths, is not uncommon for a youth who has experienced multiple hospitalizations. Michael’s relative strength, based on the information above, is his average self-concept score on the BYI-II in spite of the below average Sense of Mastery and Sense of Relatedness scores reported on the Resiliency Scales. Treatment might focus on identifying what Michael likes about himself and exploring with him how he might use that quality in relating to others and increasing his sense of mastery.

Michael also reported an average degree of Adaptability, suggesting that he may have the ability to recognize his mistakes and accept feedback from others. Therapy might involve pointing out that this is a strength that others do not have, and assisting Michael in using this ability to his best advantage. Part of this intervention should be a thorough explanation of the effects of ADHD and information on how these symptoms may have interfered in the past and how they might be managed in his future.

In summary, treatment might focus on helping Michael structure a plan for adulthood that maximizes his chances for some degree of success and satisfying relatedness with others. This plan would take his ADHD into consideration, and the importance of maintenance on medication for management of ADHD symptoms so that they do not interfere with his functioning.
The Reynolds Bully Victimization Scales are designed to identify those students who are engaging in bullying behaviour and those that are falling victim to bullying. The scales also identify those students who are experiencing significant psychological distress, both of an internalizing and externalizing nature; and helps to identify those students who show significant levels of fear and worry about their safety in school and the level of school violence. The scales are designed for use with children and adolescents aged 8 to 19 years.

The Reynolds Bully-Victimization Scales are easy to administer consisting of three self-report scales. Each scale contains statements of feelings and experiences and the child/adolescent is asked to respond as to how often they have experienced the feelings or events being described in the last month; 0 being almost never, 1 sometimes, 2 a lot of the time and 3 almost all of the time.

The self-report items are easy to understand and most students with a reading age of eight years are able to read the test items and respond without assistance. The scales can be administered individually or to a group and can also be used as a school wide screening procedure.

* Bully Victimization Scale (BVS)
The BVS consists of 46 items providing scores on two scales: the bullying scale and the victimization scale, each consisting of 23 items.

The BVS measures a range of bullying behaviours, including overt aggression i.e., throwing things, fighting and stealing. It also measures relational aggression and harassment i.e name calling and verbal threats. Responses to individual items allows the examiner to look deeper at the nature of bullying in which the student is engaged.

Items on the victimization scales include the assessment of overt peer aggression and relational aggression directed at the respondent. It measures domains of various types of peer victimization, including being physically assaulted and teased for example. Responses to the items provide useful information on the nature of the bullying experienced by the student and the frequency with which it occurs.

* Bully Victimization Distress Scale (BVDS)
The BVDS consists of two scales, the Externalizing Distress Scale and the Internalizing Distress Scale. The scales are designed to evaluate dimensions of students’ psychological distress specific to being bullied. The scales allow the examiner to determine whether the student is experiencing internalizing symptoms such as sadness or fear or externalizing symptoms of distress such as anger or aggression.

* School Violence Anxiety Scale (SVAS) Used with students aged 10-19 years only
The SVAS consists of 29 items designed to measure student anxiety about schools as unsafe or threatening environments. The SVAS measures anxiety across 3 domains: Cognitive, Physiological and Behavioural.
Technical Information

Norms for the RBVSS were developed using the stratified sample of 2000 children and adolescents in the US. Norms were developed with a sample of 1,990 students for the BVS and BVDS, and 1,587 for the SVAS. The SVAS was developed for use with students aged 10 to 19 years so a smaller standardisation sample group was used for the development of the norms for this scale, taken from the original larger sample.

Reliability of the RBVSS was examined in several studies and found to be good. High internal consistency reliabilities in the .90s were found across all the scales. Evidence of high validity was also reported.

Why choose RBVSS?

- A brief and easy to administer assessment.
- Can be used to identify both the bully and the victim.
- Profiles individual student’s perception of school, highlighting fears and anxieties to allow for intervention.
- Can be used individually or with large groups to screen a number of students at one time.
- Psychometrically sound.
- Each scale can be administered in isolation or in combination with the others allowing flexibility for the examiner to meet the needs of all students.

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Overview

Social skills are an essential and critical attribute to successful functioning in life. Children and adolescents interact with an increasing number of people in varied settings and situations, some do with ease, whilst others struggle. Well developed social skills can contribute to academic success, conversely social skills deficits can lead to poor academic outcomes and may later result in social adjustment problems.

Importantly social skills can be developed and improved; the Social Skills Improvement System (SSiS™) Rating Scales enable targeted assessment of individuals aged between 3 and 18 years, which can help to evaluate social skills, problem behaviours and academic competence that can then lead to intervention.

Features

The SSiS™ Rating Scales provides a broad, multi-rater assessment of student’s social behaviours that can affect teacher–student and parent–child relations, peer acceptance and academic performance. This multi-rater approach involves the student, parent and teacher, enabling a student-centred approach whilst also giving the other key individuals within a student’s life an opportunity to view their concerns.

The SSiS™ contains four record forms, the teacher and parent form can be used on child and adolescents from age 3 up to 18 years, whereas the student rating forms are broken down into two age appropriate groups; 8 to 12 years and 13 to 18 years.

Teachers and parents rate both the frequency and importance of each social skill item. Students rate how true each social skills and problem behaviours item is for them, whilst the older students also rate the importance of each of the social skills. This format enables the professional to receive a wide view of the students functioning and capabilities, including any strengths, weaknesses or concerns.

Administration is quick and user friendly, each form can be completed within approximately 15–20 minutes, and can either be hand-scored using straightforward handscore forms, or computer–scored using the ASSIST software.

Within the SSiS™ there are three key sub–scales; social skills, problem behaviours and academic competence. Social skills and problem behaviours are covered within all three rater questionnaires whilst the academic competence is limited to just the teacher rater form.
The sub–scales are then broken down further to specific attributes, these are:

- **Social Skills**
  - Communication
  - Cooperation
  - Assertion
  - Responsibility
  - Empathy
  - Engagement
  - Self-control

- **Problem Behaviours**
  - Externalising
  - Bullying
  - Hyperactivity/inattention
  - Internalisation
  - Autism spectrum

- **Academic Competence (Teacher form only)**

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**Technical Information**

The SSiS™ allows you to compare students to sample norms to help identify those individuals who are performing below normative expectations and who need further intervention. The SSiS™ is normed on 4,700 children and adolescents in the US. Standard Scores and Percentile Ranks are available for each subscale.

Scoring of the scales can be completed by using the separate Male and Female norms or using the combined option. The different sets of norms are provided due to the difference in scoring between the two groups, for example the average ratings for problem behaviours were consistently lower within the female group, than those for males.

Clinical samples include:
- Autism
- ADHD
- Developmental delay
- Gifted/talented
- Speech/language impairment

The SSiS is correlated with other assessments including:
- Behavior Assessment System for Children, Second Edition (BASC-2)
- Vineland Adaptive Behavior Scales, Second Edition (Vineland-II)

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Why Choose SSiS™?

Social skills are an integral part of development for all children, by using the Social Skills Improvement System Rating Scales the competencies of an individual's social skills can be investigated. The multi-rater approach enables the identification of specific social behaviour acquisition and performance, supporting you in providing the best interventions that are suited to their needs.

To aid in the ease of administration and scoring, the SSiS can be hand-scored or computer-scored using the ASSIST CD package.
Also Available in the SSiS Range...

SSiS Intervention Guide

Designed to help you plan and implement remediation strategies, this guide offers in-depth interventions for 20 key social skills and is linked directly to results from the SSIS Rating Scales; enabling you to conduct meaningful pre- and post-intervention assessments.

The guide provides units that follow a step-by-step teaching model addressing: Communication, Co-operation, Assertion, Responsibility, Empathy, Engagement, Self-control.

The SSIS Intervention Guide also provides many optional intervention strategies, resources that support instruction, and tools to monitor program effectiveness and student progress.

SSiS Classwide Intervention Program

A structured, yet flexible and efficient way to teach 10 of the most important social skills to students from preschool to early adolescence. The program has been designed in conjunction with the SSIS Performance Screening Guide to provide a co-ordinated system for improving social skills.

Program units focus on 10 social skills that consistently earned the highest importance ratings. Each of the 10 skill units is divided into three 20 to 25-minute lessons organised around the six phases.

Features & Benefits
• Includes ongoing monitoring and feedback component
• Offers materials that support home-school communications and student self-monitoring – critical elements in generalising social skills to environments beyond the classroom.

SSiS Performance Screening Guide

A time-efficient, technically sound tool for the classwide screening of key social, motivational and academic skills. For use with students in preschool through to secondary school, this universal screening instrument helps assess and document the performance level of all students, not just those in greatest need of intervention.

The SSIS Performance Screening Guide focuses on observable behaviours in four skill areas:
• Pro-social Behaviours
• Motivation to Learn
• Reading Skills
• Maths Skills.

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Behavior Assessment System for Children – Second Edition (BASC–2)

Overview

BASC-2 is a multimethod, multidimensional system used to evaluate behaviour and self-perceptions of children and adults aged 2–25 years. It is sensitive to both obvious and subtle behavioural and emotional disorders as expressed in school and clinical settings, and to academic and familial demands on child and adolescent development. It provides a sophisticated approach to the evaluation of behavioural and emotional disorders among children and adolescents.

It has five components which can be used individually or in any combination:

- Two rating scales (teacher - TRS and parent - PRS). These gather descriptions of a child’s observable behaviour, each divided into age-appropriate forms.
- A self-report scale (self-report of personality - SRP). This allows the child to describe their emotions and self-perceptions.
- A structured developmental history (SDH)
- A form to record and classify directly observed classroom behaviour (Student Observation System - SOS)
- It measures numerous aspects of behaviour and personality including positive (adaptive) and negative (clinical) dimensions.
- BASC-2 was designed to facilitate the evaluation of a variety of emotional and behavioural disorders of children and to aid in design of treatment plans.

Features

- Assesses a wide range of distinctive dimensions. As well as evaluating personality, behavioural problems and emotional disturbance, it can identify positive attributes that are useful in the treatment process.
- The range of dimensions assessed can help to make a diagnosis of a specific category of disorder such as those in the DSM-IV-TR (American Psychiatric Association, 2000) and general categories of problems such as those addressed by the Individuals with Disabilities Education Act (IDEA, 1997).
- It allows information from multiple sources to be compared to help achieve reliable and accurate diagnoses.
- Each component is designed for a specific setting or type of respondent because some behaviours are more important or measurable in some settings rather than others.
- The scales are highly interpretable because they are built around clearly specified constructs with matching item content developed through a balance of theory and empirical data.
- Scales also have high internal consistency and test-retest reliability.
- Forms can be either handscored or computer–scored.
- Norms are based on large representative samples and differentiated according to gender, age and clinical status of the child. (N.B. US Census data 2001). Clinicians can choose from gender-based norms or combined-gender norms when deriving standard scores for the various sub-scales on composites.
- It offers validity checks to help detect careless or untruthful responding, misunderstanding or other threats to validity.

www.pearsonclinical.co.uk
Why Choose BASC-2?

• Can aid clinical diagnosis of disorders that are first apparent in childhood or adolescents.
• Can be used in a variety of clinical or educational settings.
• BASC-2 is sensitive to numerous presenting problems in the classroom: academic difficulties are frequently linked to behaviour problems. It is also useful for assessing severe emotional disturbance.
• BASC-2 may be particularly useful for designing individual educational plans.
• Repeated use of the BASC-2 can help to identify a child’s progress in specific programmes.
• Uses a multidimensional approach for conducting a comprehensive assessment
• Strong base of theory and research gives you a thorough set of highly interpretable scales
• Enhanced computer scoring and interpretation provide efficient, extensive reports
• Differentiates between hyperactivity and attention problems with one efficient instrument

Technical Information

US Norms, Sample Size: 3 400 – 4 500 for each scale

There is a choice of norm groups:
• General, combined gender
• General, separate gender
• Clinical

The norms have been sampled across race, ethnicity, parent education, geographical region and clinical/special education status.

Links to other measures

Also available:
• BASC-2 BESS (Behavioral and Emotional Screening System)
• BASC-2™ Intervention Guide and Classroom Intervention Guide
• BASC-2™ Progress Monitor
• Q-global

Find out more at www.pearsonclinical.co.uk/q-global.
Overview

The Vineland–II is a measure of adaptive behaviour from birth to adulthood. There are three versions available: the survey interview form, expanded interview and teacher rating form.

The key areas that the Vineland–II assesses are:
- Communication
- Daily living skills
- Socialisation
- Motor skills
- Maladaptive behaviour

Features

- Expanded age range encompasses birth to age 90 (Survey Interview, Expanded Interview, Parent / Caregiver Rating Form) and 3 to 21 years and 11 months (Teacher Rating Form).
- Parent/Caregiver Rating Form gives you another choice, a simple rating scale, for obtaining the basic information you receive from the semi structured interview.
- All Vineland–II forms aid in diagnosing and classifying learning difficulties and other disorders, such as Autism, Asperger’s Syndrome and Developmental Delays.
- The content and scales of Vineland–II were organised within a three domain structure: Communication, Daily Living, and Socialisation.
- In addition, Vineland–II offers a Motor Skills domain and an optional Maladaptive Behaviour Index to provide more in-depth information about your clients.
- The forms can be handscored or computer–scored. The Vineland–II Survey Forms ASSIST software takes the tedium out of scoring and interpretation. It calculates derived scores easily and accurately. The software also produces detailed reports at the click of a button. Use the Survey Forms ASSIST with both the Survey Interview Form and the Parent/Caregiver Rating Form. You can enter individual item scores or sub domain raw scores.

Technical Information

The Survey Forms normative sample consists of over 3,500 individuals and the Expanded Interview Forms normative sample consists of over 2,000. Scores are provided for 94 age groups. All samples were stratified by race, mother’s education, geographic region, and special education placement and were matched to the US census.

www.pearsonclinical.co.uk
Why Choose Vineland–II?

- Updated content reflects tasks and daily living skills that are attuned to current societal expectations.
- Increased coverage of early childhood adaptive behaviour improves classification of moderate to profound learning difficulties.
- More complete coverage of adult adaptive behaviour improves detection of decline in older adults.
- Semi structured interview format now lists items by sub domain; making test administration easier.
Overview

The Gilliam Asperger’s Disorder Scale (GADS™) is a standardised screening test for use by teachers, psychologists, therapists and other professionals for the purpose of screening for Asperger’s Disorder.

A norm referenced instrument, it is quick and easy to administer taking approximately 5 - 10 minutes. It is designed to be used with individuals aged 3 to 22 years old.

Features

The GADS™ consists of four core subscales and an optional fifth subscale which can be completed by parents.

The examiner rates each item on how frequently these behaviours occur with 0 being never observed, 1 seldom observed, 2 sometimes observed and 3 frequently observed.

- **Social Interaction Subscale**
  Items on the Social Interaction Subscale describe social interactive behaviours, expression of communication intent and cognitive and emotional behaviours.

- **Restricted Patterns of Behaviour**
  Items on this subscale describe restricted and stereotyped patterns of behaviour that are characteristic of Asperger’s Disorder.

- **Cognitive Patterns**
  Items on this subscale evaluate speech, language and cognitive skills.

- **Pragmatic Skills**
  Items on this subscale are concerned with the ability to understand and use language in a social context.

- **Early Development**
  This is an optional subscale to be completed by parents or caregivers. It consists of eight questions about the individual’s early development.

(See example; Figure A on pg 2)

The examiner is able to build up a profile of an individual’s behaviours and obtain a standard score and percentile for each of the subscales. An Asperger’s Disorder Quotient can also be gained by combining the scores of the subscales. An examiner can also estimate the overall likelihood of the individual having Asperger’s Disorder using the quotient score.

(See example; Figure B on pg 2)
Gilliam Asperger’s Disorder Scale (GADS™)

Figure A

Restricted Patterns of Behavior Subscale

DIRECTIONS: Rate each item according to the frequency of occurrence. Use the following guidelines for your ratings:

0 Never Observed — You have never seen the person behave in this manner.
1 Seldom Observed — Person behaves in this manner 1 to 2 times per 6-hour period.
2 Sometimes Observed — Person behaves in this manner 3 to 4 times per 6-hour period.
3 Frequently Observed — Person behaves in this manner at least 5 times per 6-hour period.

Circle the number that best describes your observations of the subject’s typical behavior under ordinary circumstances (i.e., in most places, with people he or she is familiar with, and in usual daily activities). Remember to rate every item. If you are uncertain about how to rate an item, delay the rating and observe the person for a 6-hour period to determine your rating.

The person:

11. Shows or looks unhappy or untrue when praised, humored, or entertained........................................ 0 1 2 3

12. Shows unawareness of or need to know the needs of others................................................... 0 1 2 3

... ...

Figure B

Gilliam Asperger’s Disorder Scale

Section I. Identifying Information

Name: [Redacted]
Address: [Redacted]
Parents/Guardians: [Redacted]
School: [Redacted]
Examiner’s Name: [Redacted]

Section II. Score Summary

Subscales Raw Score SS SEM

Social Interaction: 27 12 3
Restricted Patterns of Behavior: 30 20 2
Cognitive Patterns: 30 20 2
Pragmatic Skills: 20 10 1
Daily Development: 20 10 1
Adaptations: 40 20 2
Asperger’s Disorder Quotient: 110 45 4

Figure 3.1. Example of completed page 1 of GADS Summary/Response Booklet.
Technical Information

The GADS™ was normed on a US sample of 371 individuals between the ages of 3 and 22 years who were previously diagnosed with Asperger’s Disorder.

Reliability and validity evidence is good. The internal consistency and reliability of the subscales were determined to be above .70 and in most cases were in the .80s and .90s.

Why choose GADS™?

• Brief and easy to administer.
• Short, psychometrically sound subscales.
• Good reliability and validity.
• Profile analysis available to determine where strengths and weaknesses lie.
• Widely used and recognised by a number of different professions.
Overview

The Gilliam Autism Rating Scale, now in its third edition, is one of the most widely used instruments for the assessment of Autism Spectrum Disorder in the world.

The GARS-3 assists teachers, parents and clinicians in identifying autism in individuals and estimating its severity.

Items on the GARS-3 are based on the 2013 diagnostic criteria for autism spectrum disorder adopted by the APA and published in the Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition (DSM-5).

Features

The instrument consists of 56 clearly stated items describing the characteristic behaviours of persons with autism. The items are grouped into six subscales: Restrictive, Repetitive Behaviours, Social Interaction, Social Communication, Emotional Responses, Cognitive Style, and Maladaptive Speech.

New Features of the GARS-3 include:

- Items and subscales reflect DSM-5 diagnostic criteria for Autism Spectrum Disorder.
- Forty-four new items were added to the GARS-3.
- All six subscales have been empirically determined to be valid and sensitive for identification of children with ASD.
- Normative data (N = 1859) were collected in 2010 and 2011.
- An interpretation guide in the Examiner’s Manual allows the examiner an easy and efficient method for assessing the probability of autism spectrum disorder and the severity of the disorder.
- A diagnostic validation form is included for insuring that test results meet DSM-5 criteria for autism spectrum disorder.

Technical Information

Reliability and Validity

- Internal consistency (content sampling) reliability coefficients for the subscales exceed .85 and the Autism Indexes exceed .93.
- Test-retest (time sampling) reliability coefficients exceed .80 for subscales and .90 for the Autism Indexes.
- Interrater reliability intraclass coefficients exceed .80 and .84 for the Autism Indexes.
- Correlations of the GARS-3 scores with those of other well-known diagnostic tests for autism are large or very large in magnitude.
- All new validity studies show that the test results are valid for a wide variety of subgroups, as well as for the general population.
Technical Information Continued

- Binary classification studies indicate that the GARS-3 is able to accurately discriminate children with autism spectrum disorder from children without autism (i.e., sensitivity = .97, specificity = .97, ROC/AUC = .93).
- Confirmatory and exploratory factor analyses demonstrate the theoretical and empirical validity of the subscales.
- Other validity evidence is provided in the manual.

Other Assessments by James E Gilliam

- Gilliam Asperger’s Disorder Scale (GADS)
Overview

The CARS2™ identifies children with autism and examines the severity of symptoms through ratings based on direct observations. This second edition has built upon the success of the original CARS™, expanding upon the test’s clinical value, making it more responsive to individuals on the high functioning end of the autism spectrum, whilst maintaining the simplicity and clarity of the original test.

Features

The test is based on two forms, depending upon the client either use the Standard form or the High Functioning form.

The Standard version rating book (CARS 2-ST) is equivalent to the original CARS™ questionnaire. It is designed for use with children younger than 6 years, those with communication difficulties or below average estimated IQ’s. The forms have been designed to be even easier to use than its predecessor and now includes ample room for note taking.

The Higher Functioning version rating booklet (CARS 2-HF) provides an alternative for assessing verbally fluent individuals, above the age of 6 and with IQ’s higher than 80. The higher functioning version is designed to be used with adults as well as children. Items on this scale have been modified from the original CARS™ to reflect current research regarding characteristics of people with high functioning autism or Asperger’s Syndrome.

The standard and high functioning forms each include 15 areas of behaviour defined by a unique rating system from 1 to 4 in key areas related to autism diagnosis. The areas addressed are the following functional areas (please note that some items differ between the two forms ST and HF, as mentioned):

- Relating to people
- Imitation (ST); social-emotional understanding (HF)
- Emotional response (ST); emotional expression and regulations of emotions (HF)
- Body use
- Object use (ST); object use in play (HF)
- Adaptation to change (ST); adaptation to change/restricted interests (HF)
- Visual response
- Listening response
- Taste, smell and touch response and sue
- Fear or nervousness (ST); fear or anxiety
- Verbal communication
- Non-verbal communication
- Activity level (ST); thinking/cognitive integration skills (HF)
- Level and consistency of intellectual response
- General impressions

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Technical Information

The CARS2™ builds upon the extensive use of the original version, the standard form has all the same items as the original CARS™ form and so all research and work supports both forms. The similarities between the standard and higher form, such as structure, provides a strong basis for the newer form.

The original CARS™ was developed on a sample of 1,606 in 1988, with a recent verification sample for the CARS 2-ST, which involved 1,034 individuals aged between 2 and 36 years, all of whom had a diagnosis of autism and had an IQ of 85 or lower (using measures such as the WISC-IV, Stanford-Binet and the Test of Nonverbal intelligence).

The CARS 2-HF was normed on 994 individuals aged between 6 and 57 years. All participants had an IQ of 80 or above, this intellectual skew was intentionally designed to focus on the higher functioning individuals to complement the CARS 2-ST.

Both forms provide Cut off scores, Standard Scores and Percentiles.

Why choose CARS2™?

The CARS2™ allows the flexibility of utilising IQ dependent rating forms, to specify the functioning of your clients in more accurate detail. The improvement on the original form also involves the extension of the age range, so you are no longer limited to using this autism rating scale on just children – it can now aid in diagnosis of adults with autism.
Overview

The ASRS™ was designed to effectively identify symptoms, behaviours, and associated features of Autism Spectrum Disorders (ASDs) in children and adolescents aged 2 to 18 years.

Authored by the highly respected Sam Goldstein, Ph.D., and Jack A. Naglieri, Ph.D., it is a US standardised, norm-referenced tool of the Autism Spectrum, including Asperger’s Disorder and Autism.

A valid, reliable, and carefully crafted tool, ASRS can help guide diagnostic decisions, treatment planning, ongoing monitoring of response to intervention, and program evaluation. It is suitable for use by Psychologists, Educational Psychologists, Social Workers, Paediatricians, Counsellors, Specialist Teachers, Mental Health Professionals, Occupational Therapists and Speech and Language Therapists.

Features

Using a five-point Likert rating scale, parents and teachers evaluate how often they observed specific behaviours in a number of areas such as socialisation, communication, unusual behaviours, behavioural rigidity, sensory sensitivity, and self-regulation.

ASRS Scales
- Social/Communication
- Unusual Behaviors
- Self-Regulation (ASRS [6–18 Years] only)

Treatment Scales
- Peer Socialisation
- Adult Socialisation
- Social/Emotional Reciprocity
- Atypical Language
- Stereotypical Behaviour
- Behavioral Rigidity
- Sensory Sensitivity
- Attention/Self-Regulation (ASRS [2–5 Years] only)
- Attention (ASRS [6–18 Years] only)

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Technical Information

Over 7,000 assessments were collected which included US normative data, clinical data, as well as reliability and validity research data.


In addition ratings from over 1,600 youth with a clinical diagnosis were collected to create clinical samples.

Why choose Autism Spectrum Rating Scales™?

- Brief and easy to administer in approximately 20 minutes (5 minutes short form).
- Excellent reliability, validity and test re-test data.
- Identifies symptoms, behaviors, and associated features of the full range of Autism Spectrum Disorders.
- Assesses DSM-IV-TR™ symptom criteria for ASDs.
- Short, psychometrically sound scales.
Overview

The Brown ADD Scales for Children and Adolescents® can be used for initial screening of children and adolescents suspected of having an Attention-Deficit/Hyperactivity Disorder and as a comprehensive diagnostic assessment tool in a battery of assessment instruments. The scales address a variety of AD/HD related cognitive impairments and symptoms.

The scales are designed to elicit parent, teacher and self reported observations of symptoms that may indicate impairment in executive functions related to Attention/Hyperactivity disorders, and may be used to assess impairments in monitoring and self regulating action as well as for hyperactive and impulsive behaviour.

Features

The Brown ADD Scales go beyond measures that address only hyperactivity to assess for less apparent impairments of executive functioning. The manuals explain the new understanding of ADD as complex impairments of executive functions that impact academic, social, emotional and behavioural functioning.

As with the adolescent and adult version, the children's edition features five clusters frequently associated with ADD - plus a sixth one, Monitoring and Self-Regulating Action, that encompasses problems in appropriately controlling behaviour:

- **Activation** - Organising, Prioritizing and Activating to Work.
- **Focus** - Focusing, Sustaining and Shifting Attention to Tasks.
- **Effort** - Regulating Alertness, Sustaining Effort, and Processing Speed.
- **Emotion** - Managing Frustration and Modulating Emotions.
- **Memory** - Utilizing Memory and Accessing Recall.
- **Action** - Monitoring and Self-Regulating Action.

The Brown ADD Diagnostic Form allows you to gather and integrate important diagnostic information about an individual, with cluster and total scores arriving at a diagnostic decision. The Diagnostic Form helps you conduct a comprehensive evaluation, with a set of procedures for integrating a clinical history, a co-morbidity screener, and a worksheet for integrating data from the Brown ADD Scales with standardised scores from other tests. All forms are in ready score format to enable easy scoring and analysis.
For teachers these can be used to record further observations and gather more information which may be useful if a referral is needed.

The manual of Brown ADD Scales for Children relates performance to scores from the Wechsler Intelligence Scales for Children - Third Edition (WISC III) and select subtests from the Children’s Memory Scales. The manual provides instructions for linking performance on the Brown ADD Scales with IQ and other assessment data.

**Technical Information**

Norms for the Brown ADD Scales for Children are based on a US standardization sample of 800 children. Equal numbers of participants were selected by gender within each age band (3-5, 6-7, 8-9 and 10-12 years).

A clinical sample was also collected of 208 children who fully met the criteria and had been previously diagnosed as having an Attention/Hyperactivity Deficit Disorder.

Norms for the Browns ADD Scales for Adolescents were collected from a clinical sample of students aged 12-18 years who met the criteria for Attention/Hyperactivity Deficit Disorder and were compared to a non-clinical sample of 190 students matched for age and socioeconomic level.

Reliability and validity is excellent for example internal consistency for total score is above .90 for all ages.

**Why choose Brown ADD Scales?**

- Brief and easy to administer.
- Psychometrically sound scales.
- A Total Score and Cluster Scores can be obtained.
- T scores give an indication of how much impairment an examinee is showing relative to a normal population.
- All forms in ready score format to make scoring and analysis easier.
- Information can be gathered from various sources ie teacher, parent or the student themselves.
- Information gathered from various sources can be subsequently compared and analysed.
- Addresses a comprehensive range of AD/HD symptomology.
- Explores executive cognitive functioning aspects associated with AD/HD based on Thomas Brown’s cutting edge model of cognitive impairment in ADD.

www.pearsonclinical.co.uk
Overview

The third edition of Conners™ has been designed as an in-depth, focused assessment of ADHD (Attention Deficit Hyperactivity Disorder). Conners 3™ aims to assess and screen for problems and disorders most commonly co-morbid or associated with ADHD.

With streamlined content, the third edition is a refined revision of Conners-Revised with new normative data and updated psychometric properties. The respondent-friendly translations of DSM-IV concepts allows for detailed assessment and can be used in a variety of ways:

- As an initial evaluation when the referral question – includes features of ADHD.
- As part of a re-evaluation to help determine progress in treatment, and to see if new issues have emerged
- As part of a screening evaluation to determine if further consideration should be given to the possibility of ADHD, ODD, or CD.
- When the Conners CBRS™ indicates that more thorough assessment of ADHD and associated issues must be pursued.
- For frequent administration in monitoring response to intervention. In contrast to other rating scales Conners 3™ can be administered frequently due to high test retest reliability.

The Conners 3™ has DSM-IV-based symptoms of ADHD, and has added Opposition Defiant Disorder and Conduct Disorder. It also contains symptom-level information from the DSM-IV-TR.

Features

The Conners 3™ has a modified age range (6-18 years), increased similarities across forms and has been written with teachers, parents, and students in mind.

For each item the respondent indicates how often they feel that the statement applies to the child described; 0 = Not true at all (Never, Seldom); 1 = Just a little true (Occasionally); 2 = Pretty much true (Often, Quite a bit); 3 = Very much true (Very often, Very frequently); ? = Omitted item.

Key areas measured are:

- Hyperactivity
- Impulsivity
- Executive Functioning
- Learning Problems
- Aggression
- Peer Relations
- Family Relations
- Inattention
- DSM-IV-TR Symptoms: ADHD Hyperactive / Impulsive Anxiety
- DSM-IV-TR Symptoms: ADHD Inattentive Home Life
- DSM-IV-TR Symptoms: ADHD Combined Friendships/Relationships
- DSM-IV-TR Symptoms: Oppositional Defiant Disorder Schoolwork/Grades
- DSM-IV-TR Symptoms: Conduct Disorder

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Other **important features** of the *Conners 3™* include:
- 8 Screener Items for Anxiety and Depression
- 6 Severe Conduct Critical Items - These groups of items alert the assessor to behaviors that are of significant concern at any age and warrant immediate investigation and/or intervention. e.g. fire-setting
- 3 Validity Scales- Negative Impression; Positive Impression; Inconsistency Index.

**Forms**

There are several forms available for the Parent, Teacher and Child (Self-report).

The **long form** is recommended for use when comprehensive information and *DSM-IV* symptoms are required.

**Short forms** are useful when administration of the full-length versions is not possible or practical. It is made up of a subset of items from the full-length form, representing concepts from all empirical scales, the inattention scale, and the validity scales. Both of these forms have scales that closely parallel each other.

In addition, there is a **10-item ADHD index form** available. This is a separate, brief, ADHD-focused measure with items selected as the best to differentiate between people with ADHD from individuals with no clinical diagnosis. Not only is it a useful as a quick check to see if further ADHD evaluation is warranted but it can also be useful for repeated measures.

As part of the full-length form, or available as a separate form is the **Conners Global Index**. This is a fast and effective measure of general psychopathology. Including the 10 best predictive items from the parent and teacher rating scales. It allows professionals to carefully measure the general psychopathology of their clients and determine the next steps to take in further examination. The **Conners 3GI** has proven to be a fast and effective measure and is specifically used in monitoring treatment and intervention.

**Technical Information**

**Normative Sample- US (2001 census)**
- 1200 Parent and Teacher rated (6-18yrs)
- 1000 youth self-reports (8-18yrs)
- Stratifies by age and gender
- Representative of all ethnicities/races/SES groups/geographic regions

**Internal Consistency**

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</table>

[www.pearsonclinical.co.uk](http://www.pearsonclinical.co.uk)
Why Choose Conners 3™?

- Multi-informant approach to assessment
- Links to DSM-IV
- Respondent-friendly translations of DSM-IV concepts
  - DSM-IV symptoms of ODD and CD
  - Assessment of Executive Functioning (P&T)
  - New validity scales (PI, NI, IncX)
  - Screener items for Anxiety and Depression
  - Severe conduct critical items
  - Impairment items
  - ADHD index available as separate 10-item index
- Easy Scoring options
- Scoring software generates in-depth detailed reports useful for parents and all health professionals

Links to Other Measures

During development of Conners 3™, the need for a comprehensive rating scale based on empirical research, that could be used by assessors for a wide range of clinical issues affecting children was identified. Hence the Conners Behavioural Rating Scales™ was developed and can be used in conjunction with Conners 3™ enabling a thorough assessment of children displaying clinical problems to take place.

Also available is Conners Early Childhood™ (Conners EC™) an innovative psychological instrument designed to assess the concerns of parents and teachers/childcare providers of preschool children, aged 2 years to 6 years.

Test-Retest Reliability
- .65-.94 (2-4 Weeks)

Gender Effects
- Girls with ADHD are often not diagnosed because they don’t typically exhibit the same symptoms as their male counterparts. The Conners 3™ can be useful in discerning between gender specific differences.
- T-scores are calculated based on youth’s age and gender to adjust for these differences

www.pearsonclinical.co.uk
The Conners Comprehensive Behaviour Rating Scales™ (Conners CBRS™) is an instrument designed to provide a complete overview of child and adolescent disorders and concerns.

Those working in the field of child and youth psychology can now use the Conners CBRS to assess a wide spectrum of behaviours, emotions, and academic problems in today’s youth.

The Conners CBRS includes the following scales:
- Empirical
- Rational
- DSM-IV TR™ Symptom
- Validity
- Clinical Indicators
- Impairment

This assessment is suitable for ages 6 to 18 years for parent and teacher forms and 8 to 18 years for self-report forms.

Conners CBRS™ uses three different questionnaires from different raters (parent, teacher and self report) to assess the following areas:

- Emotional distress
  - Upsetting thoughts
  - Worrying
  - Upsetting thoughts/physical symptoms
  - Social anxiety
- Aggressive behaviours
- Academic difficulties
  - Language
  - Maths
- Hyperactivity
- Hyperactivity/impulsivity
- Social problems
- Separation fears
- Perfectionistic and compulsive behaviours
- Violence potential
- Physical symptoms

Conners CBRS™ can be scored by hand or by computer using the scoring and reporting software.

www.pearsonclinical.co.uk
Conners Comprehensive Behaviour Rating Scales™ (Conners CBRS™)

Forms

Conners CBRS Parent Rating Scales
Assess behaviours, concerns and academic problems in children between the ages of 6 and 18 years and are reported by parents. The form is available in one comprehensive length (Conners CBRS–P) and is recommended for initial evaluations if time allows. When used in conjunction with teacher ratings, differences between home and school are highlighted.

Conners CBRS Teacher Rating Scales
These scales enable teachers to report on the items covered in the Parent Rating Scales, from a school perspective. The scales provide comprehensive results and when used with the parent scale highlight behavioural differences occurring between home and school. If time allows the Conners CBRS–T is recommended for initial evaluations.

Conners CBRS Self-Report Rating Scales
Conners 3rd Edition™ self-report forms measures behaviours, concerns, and academic problems in children 8 and 18 years old. This version provides more comprehensive results, and is recommended for initial evaluations.

Conners CBRS Clinical Index
The Conners CBRS™ offers a 25-item Conners CBRS Clinical Index which is available for parents, teachers and youth. The brief index works well when screening a large group of children and adolescents to see if further assessment of a number of disorders such as social phobia, Asperger’s disorder and manic episode is warranted. The Clinical Index is a useful tool which can help build support for whether a child is likely to have a clinical diagnosis, or is more similar to youth who do not have a clinical diagnosis.

Technical Information

Total sample:
2281 parents
2364 teachers
2057 self report (8-18)

Clinical sample (included in total sample):
704 parents, 672 teachers, and 700 self report.

- ADHD inattentive
- ADHD hyperactive-impulsive
- ADHD combined
- Disruptive behaviour disorders
- Learning disorders
- Anxiety disorder
- Major depressive disorder
- Bipolar disorder
- Pervasive developmental disorder

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Why choose Conners CBRS™?

- Direct and clear links to the DSM-IV-TR and the Individuals with Disabilities Education Improvement Act 2004 (IDEA 2004)
- Straightforward administration, scoring and reports
- Excellent reliability and validity
- Assists in the diagnostic process
- Identifies and qualifies students for inclusion or exclusion in special education/research studies
- Assists in the development of intervention treatment plans
- Monitors the child or adolescents response to intervention/treatment
- Evaluates the effectiveness of intervention/treatment plans

Links to other measures

Also available:
- Conners 3rd Edition™ (Conners 3™)
- Conners Early Childhood™

www.pearsonclinical.co.uk
Online and In-Touch

Keeping up to date with Pearson Assessment’s latest developments has never been easier. You can now:
* Follow @PsychCorpUK on Twitter
* Like our Facebook group at www.facebook.com/psychcorpuk
* Read our blog at http://psychcorpuk.wordpress.com
* Follow our Pinterest boards at www.pinterest.com/psychcorpuk
* Register for our bimonthly enewsletters at www.pearsonclinical.co.uk/enewsletters

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## Overview of Assessments

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<thead>
<tr>
<th>Test Type/Name</th>
<th>Age Range</th>
<th>Purpose</th>
<th>For Use By</th>
<th>Education Catalogue</th>
<th>Price (exc VAT)</th>
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<tbody>
<tr>
<td><strong>Personal Strengths</strong></td>
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<tr>
<td>Self image profiles (SIP)</td>
<td>7 to 16 yrs</td>
<td>Quickly assess self image and self esteem in children and adolescents</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>72</td>
<td>£104.00</td>
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<tr>
<td>978 0 749120 48 1</td>
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<tr>
<td>Self image profiles (SIP-A)</td>
<td>16 to 65 yrs</td>
<td>Quickly assess self image and self esteem in adults</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>72</td>
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<td>978 0 749134 95 2</td>
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<tr>
<td>Resiliency Scales for Children and Adolescents™</td>
<td>9 to 18 yrs</td>
<td>Profile child and adolescent personal strengths as well as vulnerability</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>53</td>
<td>£105.50</td>
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<td>978 0 158234 63 2</td>
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<td><strong>Social and Emotional</strong></td>
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<tr>
<td>Beck Youth Inventories™ - Second Edition For Children and Adolescents (BYI-II)</td>
<td>7 to 18 yrs</td>
<td>Evaluate children’s and adolescents’ emotional and social impairment</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>52</td>
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<td>Reynolds Bully- Victimization Scales for Schools</td>
<td>8 to 17 yrs</td>
<td>Screen for children and adolescents who engage in bullying behaviour or are the victims of bullying</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>55</td>
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<tr>
<td>Social Skills Improvement System Rating Scales (SSiS)</td>
<td>3 to 18 yrs</td>
<td>Gain detailed diagnostic information with direct links to intervention</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>70-71</td>
<td>£261.00</td>
</tr>
<tr>
<td>Behavior Assessment System for Children, Second Edition (BASC-2)</td>
<td>2 to 25 yrs</td>
<td>Assess behaviour and emotions in children and adolescents</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>57, 87</td>
<td>Kit from £265.50</td>
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<tr>
<td>Aggression Questionnaire (AQ)</td>
<td>9 years to 88 yrs</td>
<td>Measure aggressive behaviour in any setting - in children or adults</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>56</td>
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<td>Adaptive Behaviour</td>
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<td>Adaptive Behavior Assessment System © (ABAS) - Second Edition</td>
<td>Birth to 89 yrs</td>
<td>Assess the level of adaptive skills in children and adults</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>69</td>
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<td>Vineland Adaptive Behavior Scales, Second Edition (Vineland-II)</td>
<td>Birth to 90 yrs</td>
<td>Measure adaptive behaviour from birth to adulthood</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>68</td>
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<tr>
<td>Autism/Asperger’s</td>
<td>3 to 22 yrs</td>
<td>Help to identify and diagnose autism</td>
<td>Teachers, CAMHS professionals, Psychologists</td>
<td>65</td>
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<tr>
<td>Gilliam Autism Rating Scale - Third Edition (GARS-3) 978 0 74916654 0</td>
<td>2 yrs and older</td>
<td>Revised and enhanced, the CARS2 covers the entire spectrum, including Asperger’s Syndrome</td>
<td>Teachers, CAMHS professionals, Psychologists</td>
<td>63</td>
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<tr>
<td>Childhood Autism Rating Scale - Second Edition (CARS2) 978 0 749144 83 8</td>
<td>3 to 22 yrs</td>
<td>Identify children who may have Asperger’s Disorder</td>
<td>Teachers, CAMHS professionals, Psychologists</td>
<td>65</td>
<td>£111.00</td>
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<tr>
<td>Gilliam Asperger’s Disorder Scale (GADS) 978 0 749120 98 6</td>
<td>5 to 18 yrs</td>
<td>Identify children who may have Asperger’s Syndrome</td>
<td>Teachers, CAMHS professionals, Psychologists</td>
<td>66</td>
<td>£111.00</td>
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<tr>
<td>Asperger Syndrome Diagnostic Scale (ASDS) 978 0 761618 38 6</td>
<td>2 to 18 yrs</td>
<td>Measure behaviours associated with the Autism Spectrum Disorders (ASD)</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>64</td>
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<td>Autism Spectrum Rating Scales™ (ASRS) 978 0 154010 25 4</td>
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<td>ADHD</td>
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<tr>
<td>Brown Attention-Deficit Disorder Scales® (Brown ADD Scales®) for Children and</td>
<td>3 to 18 yrs</td>
<td>Screen for reliable indications of ADD in children and adolescents</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>59</td>
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<td>Adolescents</td>
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<tr>
<td>Brown Attention-Deficit Disorder Scales® (Brown ADD Scales®) for Adolescents</td>
<td>12 to adult</td>
<td>Screen for reliable indications of ADD in adolescents and adults</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>59</td>
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<td>and Adults</td>
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<tr>
<td>Conners 3rd Edition™ (Conners 3™)</td>
<td>6 to 18 yrs</td>
<td>Offers a thorough assessment of ADHD</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>60</td>
<td>£489.50</td>
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<tr>
<td>Conners Comprehensive Behavior Rating Scales™ (Conners CBRS™)</td>
<td>6 to 18 yrs</td>
<td>Assess behaviours, emotions and academic problems</td>
<td>Specialist teachers, CAMHS professionals, Psychologists</td>
<td>61</td>
<td>£271.50</td>
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<tr>
<td>Intervention Materials</td>
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<tr>
<td>Cogmed Working Memory Training 978 0 749163 46 4</td>
<td>4 years and older</td>
<td>An evidence-based intervention for improved working memory</td>
<td>Specialist teachers,</td>
<td>19, 75</td>
<td>From £400.00</td>
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<tr>
<td>Practical Ideas That Really Work for Students with ADHD (Preschool to 9 yrs)</td>
<td>Preschool to 9 yrs</td>
<td>Practical ideas, activities and solutions for problem behaviours stemming from inattention, impulsivity and hyperactivity. Includes reproducible pages and evaluation forms</td>
<td>Unrestricted</td>
<td>81</td>
<td>£63.00</td>
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<tr>
<td>Practical Ideas That Really Work for Students with ADHD, Second Edition (10 yrs to 17 yrs)</td>
<td>10 to 17 yrs</td>
<td>Practical ideas, activities and solutions for problem behaviours stemming from inattention, impulsivity and hyperactivity. Includes reproducible pages and evaluation forms</td>
<td>Unrestricted</td>
<td>81</td>
<td>£63.00</td>
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<tr>
<td>Practical Ideas That Really Work for Students with Autism Spectrum Disorders - Second Edition</td>
<td>4 to 17 yrs</td>
<td>Practical ideas and instructional strategies that can be used to improve the student’s social interaction and communication. Includes reproducible pages and evaluation forms</td>
<td>Unrestricted</td>
<td>82</td>
<td>£63.00</td>
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<tr>
<td>Practical Ideas That Really Work for Students with High Functioning Autism</td>
<td>4 to 18 yrs</td>
<td>Practical ideas and instructional strategies that can be used to improve the student’s social skills, organisation and communication. Includes reproducible pages and evaluation forms</td>
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<td>Practical Ideas That Really Work for Students with Disruptive, Defiant, or Difficult Behaviors, Second Edition (Preschool to 9 years)</td>
<td>Preschool to 9 yrs</td>
<td>Practical ideas focusing on areas of problematic Disruptive, Defiant or behaviour commonly reported amongst school age students. Includes reproducible pages and evaluation forms</td>
<td>Unrestricted</td>
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<td>£63.00</td>
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<td>Practical Ideas That Really Work for Students with Disruptive, Defiant, or Difficult Behaviors, Second Edition (10 to 17 years)</td>
<td>10 to 17 yrs</td>
<td>Practical ideas focusing on areas of problematic Disruptive, Defiant or behaviour commonly reported amongst school age students. Includes reproducible pages and evaluation forms</td>
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<td>£63.00</td>
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A range of products suitable for addressing social, emotional and behavioural needs

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